Consultants are an integral part of the medical care team in long-term care facilities. Attending physicians rely on consultants to obtain needed knowledge or provide specialty care to residents. Communications between attending physicians, consultants, and other members of the care team is crucial to quality care, error prevention, and risk management. The importance of a well-structured and defined system to ensure availability of consultations, timeliness of consultants’ visits and care, and communications between consultants and attending physicians is underscored by negative patient outcomes and legal liability resulting from lack of such systems.

A recent article in this Journal reports a patient who was admitted to a nursing facility after an ankle fracture was set and a cast applied in a hospital’s emergency department (ED). The patient was admitted with an order to be seen the next day by a podiatrist privileged to treat ankle fractures. The ED physician did not order prophylaxis for deep vein thrombosis. When the podiatrist came to the facility the next morning, she was not allowed to see the resident because she was not on the approved panel of the resident’s managed care insurance. The managed care organization was not called to send someone else, and no one else, including the attending physician, examined the resident or ordered any treatments. The resident died a day later due to pulmonary embolism. A lawsuit against the nursing facility for failing to provide adequate medical follow-up was later settled. This case illustrates the importance of facility responsibility to ensure services regardless of payer source; availability, credentialing, and timely visits by appropriate practitioners; and the facility’s and attending physician’s responsibility to ensure that needed services are provided.

In a well-publicized case in New York, a patient erroneously received enteral feedings via a peritoneal dialysis tube. When the error was discovered, the attending physician called the patient’s nephrologist. The exact nature of the conversation between the attending physician and the consultant was in dispute and was not documented. The attending physician delayed sending the patient to a hospital, where the patient subsequently died. Because of this delay, the physician faced criminal prosecution for reckless endangerment of the patient and violation of the state’s health laws. Prosecutors said that the nephrologist advised the attending physician to get the patient promptly into the hospital, but the physician did not follow this advice in order to cover up the error. The physician was eventually convicted, not because of the original error, but because of the delay in hospitalization. The issue of communication with a consultant played a central role in the prosecution of this case.

Recent articles in this Journal reviewed the roles and responsibilities of attending physicians in long-term care facilities. The present article reviews systems and processes that facilities and medical directors may develop and implement to ensure availability and provision of consultations, the roles and responsibilities of attending physicians to appropriately order consultations and communicate with consultants, and the roles and responsibilities of consultants in long-term care facilities.

**WHO IS CONSIDERED A CONSULTANT?**

A consultant is a professional who possesses additional knowledge base and/or skills beyond the scope of the primary care attending physician. The definition of “primary care” may vary. Many practitioners consider themselves primary care providers; these include family physicians, internists, geriatricians, gynecologists, dentists, podiatrists, optometrists, clinical psychologists, audiologists and others. In a nursing facility, the medical director, in accordance with local needs and customs, should develop clear definitions of which services are considered primary care or consultative.

**WHO CAN SERVE AS A CONSULTANT IN A SKILLED NURSING FACILITY?**

Facilities and medical directors must decide who may serve as consultant in a facility, depending on local factors, accreditation status, and state statutes. When there are no restrictions on practice in the facility, medical directors should protect attending physicians and residents by establishing a protocol to ensure minimal qualifications, licensure, and malpractice insurance coverage for consultants. Medical directors...
are encouraged to establish formal procedures for credentialing and privileging all practitioners, including consultants. Joint Commission on Accreditation of Healthcare Organizations-accredited facilities are required to have such a process.7 This process ensures that consultants possess appropriate qualifications to provide evaluation and management services as well as procedures and other interventions. The credentialing process usually applies only to consultants who practice within the facility, and not to consultants to whose offices or clinics residents are referred.

Consultants may be members of the medical staff in facilities with organized medical staff or may provide services by contractual relationship with the facility. Procedures must be developed to deal with requests by physicians, residents or families for noncredentialed consultants to provide services in the facility when occasional need occurs. Such procedures should define the minimum requirements to allow such services (Appendix I).

ACCESS TO CONSULTANT SERVICES

Medical directors and facilities should work to ensure that consultants are available to residents of the facility, either in the facility or within a reasonable distance by transportation. This is not required by regulations, but is clearly in the best interest of providing quality care to facility residents. Facilities and medical directors should also ensure that consultation services are available to all residents regardless of payment source, either on site or in consultants’ offices or outpatient clinics. Problems with provision of consultations may arise when the resident has certain managed care or insurance coverage in which facility consultants do not participate, or has no source of payment. Facilities and medical directors should develop policies and procedures to deal with such situations so that needed services can be provided. They must ensure that consultations are available to residents on a variety of reimbursement arrangements. For example, when the facility contracts with managed care organizations, it must ensure that there are available consultants on that organization’s panel to see residents. This issue should be addressed during contract negotiations with managed care organizations.

Large facilities or facilities that generate a large number of consultations in specific specialties should consider developing specialty clinics within the facility. This is an efficient way to provide services to large number of residents and reduce need for transportation and resident inconvenience. Many facilities already provide such clinics in specialties like ophthalmology, orthopedics, or psychiatry.8 These clinics require not only additional space and equipment but also appropriate staff assistance and organization. For example, even if radiology services are not located in the facility, staff need to ensure that X-rays are available for viewing at the time clinics such as orthopedics or psychiatry are held, requiring coordination with outside radiology providers.

WHO CAN ORDER A CONSULTATION?

Whereas residents are allowed direct access to practitioners considered primary care providers, the attending physician or mid-level practitioner acting on behalf of the attending physician must order the services of a consultant. The rationale for this policy is the maintenance of complete control by the primary care practitioner over medical care and maintenance of regulatory compliance. It should not be intended to prevent or impede any access to care or services, or have the practical effect of doing so. Moreover, procedures should be available to enable residents and families to request consultations or second opinions (Appendix I).

Policies must be developed to define whether anyone other than the primary care attending may order consultations. Can nurse practitioners (NP) or physician assistants (PA) independently order consultations? Can consultants order additional consultations by subspecialists? For example, some facilities allow podiatrists to order orthopedic consultations, optometrists to order ophthalmology consultations, or psychiatrists to order clinical psychology evaluations and treatment. Regardless of the policy, in any situation when a professional other than the attending physician orders a consultation, it is important to ensure that communication with the primary care physician is maintained.

A protocol should also be developed to define if and when follow-up visits by consultants require a new order by the attending physician, and under what circumstances a consultant may provide follow-up as needed without a new order or assume the clinical care of the resident in a specific area of specialty.

WHO IS RESPONSIBLE TO ENSURE THAT A CONSULTATION IS DONE WHEN ORDERED?

When a consultation is ordered, the facility must have appropriate procedures to ensure notification of the consultant or arrange for transportation when an outside consultant is used. There should also be procedures to ensure that the consultation in fact is carried out, and if not done within an appropriate time given the resident’s condition, that the attending physician and/or medical director are notified so that appropriate action can be taken to ensure that the resident receives care. However, regardless of the facility procedure, the attending physician is still responsible for ensuring that the consultation and any recommended service is carried out (Appendix II).

DETERMINATION AND DOCUMENTATION OF MEDICAL NECESSITY FOR CONSULTATION SERVICES

Primary care practitioners must document the medical necessity for each service they order when it is reimbursed under Medicare and Medicaid. Medical necessity for consultations exists when a consultant possesses additional knowledge base or skills clearly beyond the scope of the attending physician; the service requested is appropriate for the resident; and the service will affect the resident’s assessment, diagnosis, or care planning and treatment.9 The ordering practitioner must document the medical necessity for ordering each consultation. The Medicare Carrier Manual10 requires that a consultation be provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate source; the request for a consultation from an appropriate source and the

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need for consultation must be documented in the medical record; and a written report must be provided to the referring physician. The manual specifies that nurse practitioners and physician assistants may request consultations and that consultants may initiate diagnostic or therapeutic services.

Initial consultation visits may be billed using a consultation CPT code (initial inpatient, 99251–99255) when the above requirements are met. Follow-up visits can be billed using a follow-up inpatient consultation code (99261–99263) when the visits are requested by the attending physician and intended to complete the initial consultation, such as monitoring progress or recommending management or care plan changes. Other subsequent visits, such as visits for the purpose of managing a portion of or the entire patient's clinical condition, should be billed under subsequent nursing home care codes (99311–99313). Finally, confirmatory consultation codes (99271–99275) can be used when a second or third opinion or advice are requested by the patient. Additional consultation issues that may apply in the nursing facility setting, such as consultations requested by members of the same group and preoperative and postoperative clearance and care, are also covered by the Medicare Carrier Manual. Physicians should be aware of Local Medical Review Policies issued by their local Medicare carriers, which may not always be entirely consistent with the national policy as described in the Medicare Carrier Manual.

Standing Orders

Medicare requires that medical necessity be established for each specific service. However, there are conditions that require specialty assessment and follow-up on a regular basis when such services are beyond the scope of practice of primary care physicians. Medical directors may establish guidelines, and even require attending physicians to order, certain specialty consultations or regularly scheduled consultants' visits or supervision of care. For example, a facility may require initial assessment and/or periodic follow-up visits by an ophthalmologist for residents with diabetes or glaucoma, or a psychiatric consultation and/or follow-up visits for residents with certain mental illnesses such as schizophrenia or major depression.

Responsibilities of the Attending Physician

The order for consultation should specify the specialty and, depending on facility protocol, the name of the requested consultant. The order should also specify whether the request is routine or emergency and the reason for requesting the consultation. Depending on facility policy (see below), the order may need to specify if a consultant is authorized to initiate care. Once a consultation is ordered, the attending physician is obligated to follow up to ensure that the consultation is done and the results communicated. The attending physician should document, order, or follow the consultant’s recommendation, or document why recommendations are not followed. When facility policy allows the consultant to provide the care, the attending physician should be aware of the care provided and preferably document his or her agreement with the consultant's care plan. The attending physician is also responsible to ensure that follow-up visits and care are performed as suggested by the consultant or document the reason why that is not done. The ultimate responsibility for following recommendations of a consultant is borne by the attending physician. For example, if a consultant recommends surgery, the attending physician must decide if such an intervention is appropriate for that particular resident in the context of the resident’s overall medical, functional, and psychosocial condition as well as the resident’s quality of life.

The Consultant Role in Providing Care to Residents

It is imperative to establish facility protocols to clarify whether consultants provide only recommendations, or are expected to write orders directly in the medical record and initiate interventions and/or medical procedures. When consultants are allowed to independently write orders and initiate interventions, care may be more expedient but may be prone to miscommunications between the consultant and the attending physician resulting in medical errors. A system allowing consultants to provide only advice and recommendations, with the final decision-making remaining in the hands of the primary care attending physician, requires procedures to ensure timely communication of consultants’ recommendations to, and response by, the attending physician. This system potentially increases the time the attending physician needs to spend on sorting out treatment options and coordination of care, may be prone to errors in the additional steps of the process, and may risk delays in carrying out the recommendations. In addition, this system has an advantage in ensuring the attending physician's awareness of the recommendations and control and coordination of the resident’s medical care. Consultants rarely possess a full knowledge of a long-term care resident’s medical, functional, and psychosocial condition and often are not aware of quality of life issues. These considerations are paramount in deciding the appropriateness of various interventions and treatment options.11 As mentioned above, in long-term care the appropriateness of an intervention, such as a surgical procedure, is rarely dependent solely on the resident’s medical condition. The attending physician, working with the care team, the resident, and the family, is best suited to make such decisions.

Responsibilities of Consultants

The responsibilities of consultants should be spelled out in the medical staff by-laws, facility medical policies, or in contractual agreements with consultants. Consultants should be required to abide by the facility's medical staff by-laws or policies, as well as federal, state, and local regulations and compliance requirements. Specifically, facility protocols should require consultants to provide services in a timely fashion, which depends on the resident’s clinical condition, but a maximum acceptable limit should be set, such as 7 days for a routine request or 24 hours for an emergency request.

At a minimum, consultants must clearly and legibly document the following:

- Pertinent history;
• Pertinent physical examination finding;
• Diagnosis or at least a working diagnosis;
• Care plan;
• Services and interventions provided and procedures performed;
• Recommendations for diagnostic services, treatments, procedures, monitoring, or other services.

When consultants provide additional services and procedures, they should proceed only after communicating with the attending physician, when specifically asked by the attending physicians, or otherwise pursuant to facility protocols.

In addition to providing a written, signed, and dated report, consultants should communicate their findings and recommendations to the attending physician in a timely manner as required by the resident’s clinical condition. In general, a written report is sufficient, but verbal communication should be encouraged when the resident’s clinical condition requires immediate action. In any case, the facility should have a procedure in place to ensure that consultants’ recommendations are communicated to the attending physicians in a timely manner. This procedure should also ensure that orders to proceed with the recommendations, if indicated, are obtained in a timely manner.

As discussed above, a system that requires consultants to provide advice and recommendations and attending physicians to approve and order the care has an advantage of ensuring that the attending physician is aware of all aspects of the resident’s care and facilitating care coordination, but may cause delays in provision of care due to delayed communications. To prevent delay, facilities and medical directors should consider developing protocols setting forth which consultants may write orders directly in the medical record without pre-approval of the attending physician. In such instances, a system must be in place to communicate these orders to the attending physician, for example, by requiring co-signature. Procedures should also be developed to facilitate the assumption of care when it is necessary for a consultant to assume the ongoing care of a clinical aspect of the resident’s condition.

The consultant should recommend any needed follow-up and the rationale for such follow up. Generally, the attending physician should approve follow-up visits and care by a consultant, except when follow-up is bundled with the initial consult, such as surgical follow-up, or when a specific service usually and customarily requires more than one visit. When a consultant assumes the ongoing care of a resident for a specific problem (such as commonly occurs in psychiatry, ophthalmology, and surgery), ongoing communication with the attending physician, and often some coordination, are essential to provide appropriate care and prevent errors. For other recommended follow-up visits and services, the facility and medical director must develop a system to ensure that recommendations for follow-up visits are recorded and subsequently ordered and completed. Although the attending physician retains the ultimate responsibility for the ordering such services in a timely fashion, it is not realistic without the support of facility staff and the presence of a functioning system, such as a computerized reminder system to ensure that follow-up care requested is obtained even after the passage of considerable amount of time.

As with attending physicians, consultants may delegate to mid-level practitioners any medical care related task when such task is within the practitioner’s scope of practice in compliance with applicable state regulations. The consultant may not delegate any task to a mid-level practitioner when federal or state regulations require such task to be performed personally by a physician.

Consultants, particularly those who participate in the care of residents and write orders in the medical record, should be aware of regulatory requirements concerning medications as well as facility medication policies and formularies. In fact, consultants such as psychiatrists or clinical psychologists may play an important role in assisting the facility and the medical staff in maintaining regulatory compliance, while at the same time providing quality mental health care. Consultants’ medication orders are subject to drug regimen review by the consultant pharmacist. Most consultants are not familiar with the need to interact with consultant pharmacists and respond to recommendations and should become aware of the role of the consultant pharmacist and the positive effect of a drug regimen review on the quality of pharmaceutical care.

**COMMUNICATIONS BETWEEN ATTENDING PHYSICIANS AND CONSULTANTS**

Timely communication of findings and care recommendations between consultants and attending physicians is crucial to preventing medical error and ensuring quality care. Attending physicians are responsible to communicate to consultants the reason for requesting a consultation and any appropriate information the consultant may need. The facility must have a system to facilitate such communication. Attending physicians are also responsible for the appropriate follow-up on all consultants’ recommendations. They should review and act on the consultants’ reports, findings, and recommendations in a timely manner and include this review and care decisions in their own progress notes. There should be a clear understanding between the attending physician and the consultant in situations when the consultant assumes the ongoing clinical care of the resident. This is not uncommon in certain specialties, such as psychiatry.

Consultants who come to the facility have access to the medical records and members of the interdisciplinary team and are able to secure clinical information about the resident while on site. But facilities often have to obtain consultation and other specialty care from off-site consultants, clinics, hospitals, and even emergency departments. It is crucial to develop a system for transferring appropriate clinical information when residents are sent for such consultations or care. At a minimum, facilities should provide copies of the resident’s history and physical examination forms, recent monthly or bimonthly and interim progress notes, a list of active medical conditions (such as medical face sheet), medication orders and relevant laboratory and diagnostic tests. Attempts should also be made to ensure that appropriate information returns with the resident. This is particularly important when...
Table 1. Essential Medical Director Roles in Ensuring Consultant Services

The medical director should:
1. Ensure availability of consultants in all relevant specialties to all residents, residents on a variety of reimbursement plans, and regardless of payment source
2. Ensure minimum qualifications of consultants or develop a credentialing and privileging process
3. Assist consultants in meeting regulatory and compliance requirements
4. Educate consultants on geriatric and long-term care practice principles
5. Develop and implement policies and procedures to ensure appropriate and efficient provision of consultation services to residents that:
   - define primary care practitioners and consultants
   - define which practitioners are authorized to order consultations
   - allow residents and families to request consultations and second opinions
   - allow noncredentialed consultants to see residents in the facility when necessary or requested
   - require documentation of consultations’ medical necessity
   - list information to be conveyed to consultant on and off site
   - ensure that consultations are done when ordered
   - ensure timely communication of consultants’ reports to attending physicians
   - require documentation of recommendations follow-up (or lack thereof) by attending physicians
   - define when and how follow-up visits are ordered
   - organize specialty clinics when appropriate and feasible
6. Develop policies and procedures to define the roles and responsibilities of consultants in the facility that:
   - define which consultants provide advise and recommendations and who may provide orders, initiate care or assume ongoing care of a clinical problem
   - ensure timely provision of consultations on and off site
   - define documentation requirements of consultants
   - ensure communication of recommendation, orders or interventions and care provided to attending physicians
   - provide for appropriate and timely monitoring and follow-up by consultants
   - ensure coordination of care when a consultant participates in the resident’s care
   - address delegation to mid-level practitioners
7. Monitor consultants’ performance and adherence to policies and procedure
8. Ensure quality of care provided by consultants

Dear [Name],

Care and treatments are provided off site, such as surgical procedures, hemodialysis, or chemotherapy.

ROLE OF THE MEDICAL DIRECTOR

The medical director is responsible for the coordination of medical care in the facility. The medical director should arrange for consultants to be available. Consultants may not be familiar with the regulatory requirements of long-term care or with the care of frail elderly. The medical director has an opportunity to educate consultants in principles of geriatric medicine and the special aspects of long-term care practice, and has the responsibility to assist consultants in meeting regulatory and compliance requirements. The medical director should develop policies and procedures to ensure efficient provision of consultation services to facility residents and to delineate the roles and responsibilities of consultants (Table 1). Attending physicians and consultants should participate in the process of developing these policies and procedures. The provision of quality care requires at a minimum that consultations are done when ordered, documented properly, results are communicated to the attending physicians, recommendations are followed, and appropriate follow-up visits and care by consultants are done. The medical director should develop systems to monitor and evaluate consultants’ performance and adherence to facility policies and procedures. The medical director should also ensure the provision of quality medical care by consultants.

REFERENCES

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APPENDIX I. SAMPLE CONSULTATIONS POLICY AND PROCEDURE

1. Consultations may only be ordered by primary care physicians, a nurse practitioner, or a physician assistant.

2. An order is necessary for all initial consultations except dental services. An order is not necessary for dental consults and follow-up visits.

3. For routine requests, consultation will be done within 7 days, or as soon as specified by the requesting physician.

4. For urgent requests (or in cases of emergency), consultation will be done as soon as possible, but no later than within 24 hours.

5. A consultant who is not a member of the medical staff may be called to see a resident in the facility upon the request of the resident or the family/responsible party, or upon the request of the primary care physician. The medical director must approve such consultation in advance. A consultant who is not a member of the medical staff must provide a copy of a valid state license and a malpractice insurance certificate acceptable to the facility before approval by the medical director.

6. If an appropriate consultant is not available on the staff, or at the resident’s or family/responsible party’s request, the resident may be transferred for a consultation to the offices of any consultant of their choice. The primary care physician must order the consultation. In the case of a resident or family/responsible party request, such consultation may also proceed when the primary care physician objects; however, the medical director must be notified.

7. Consultations shall be done in the facility.
   a. At the primary physician’s or the consultant’s request, the resident may be transferred to an office or a hospital outpatient department for provision of consultation when use of instruments or procedures not available in the facility are necessary.
   b. Such transfers must be approved and ordered by the primary care physician.
   c. Appropriate information (including consultation request form completed by the requesting practitioner, history and physical examination (H&P) form, list of active medical problems, medication orders sheet, and relevant laboratory and diagnostic tests) must be sent to the consultant along with resident.

8. All orders for initial consultations and follow-up visits by consultants must be written by the physician to specify:
   a. Specialty and/or consultant’s name
   b. Time frame (when appropriate)
   c. The medical necessity for the consultation ordered
   d. This must be documented in the physician’s progress note at the time of the order.
   e. The physician shall complete, sign, and date the consultation request form.

9. Consultants shall write a report on the facility’s approved consultation form, and shall make recommendations when appropriate. The consultation form must be signed and dated.

10. Consultants may write orders on the order sheet for additional laboratory and diagnostic tests and medications or treatments only if approved by the medical director.

11. The primary attending physician shall review the consultant’s report and recommendations, sign the consultation form to acknowledge this review, enter the appropriate note in the interim or monthly (periodic) progress note, and order appropriate follow-up visits as per the consultant’s recommendations, when medical necessity exists.

12. The primary attending physician is responsible for the appropriate follow-up on all consultants’ recommendations.

13. The consultant may delegate to a NP or PA any other medical care-related task when such task is within the NP or PA scope of practice in compliance with facility NP and PA policies as well as applicable state regulations. The consultant may not delegate any task to a NP or PA when federal or state regulations require such task to be performed personally by a physician.

14. Consultants who bill the Medicare program agree to abide by billing policies and procedures as established in the Centers for Medicare and Medicaid Services (CMS) Medicare Carrier Manual. Specifically, only the first visit can be billed under a consultation code; all additional follow-up visits must be billed under follow-up codes, as appropriate.

Second Opinion. Any resident or designated representative may seek a second opinion if the resident or responsible party disagrees with the diagnosis or treatment being provided, and may call in a specialist selected by the resident or designated representative. Consultations of this nature must be arranged and paid for by the resident or designated representative. The primary attending physician and the medical director must be notified of such consultation. Such consultant must document the consultation report in the medical record. The facility cannot give assurance that the primary attending physician will follow such consultant’s advice.

APPENDIX II: SAMPLE POLICY AND PROCEDURE FOR ASSURING TIMELY COMPLETION OF CONSULTATIONS

1. The primary care physician, PA, or NP completes a consultation request form according to the facility’s consultation policy.

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2. Orders shall be addressed according to facility policy. Consultant orders should be placed on the daily nursing 24-hour report form.

3. For nonemergency orders, the staff assigned to take off orders shall notify the consultant's office to arrange for the consultant to visit, or make an appointment and arrangements for transportation to the consultant's office or clinic, within the next 7 days.

4. For emergency consultations to be done in the facility, the staff assigned to take off orders shall notify the consultant to arrange for the consultant to visit, or make an appointment and arrangements for transportation to the consultant's office or clinic within the next 24 hours. The notification shall include the resident's name and location, the referring physician name, and the emergency nature of the request.

5. Consultants who hold regular weekly clinics in the facility do not require notification. The staff assigned to take off orders shall compile a list of residents with pending consultations for each consultant, to be given to the consultant at the scheduled day of arriving at the facility.

a. The lists of psychiatry consultation requests are delivered to the social services department. The social service department shall prioritize the requests and provide them to the psychiatrist at the time of scheduled visit.

6. At the time of departure for a consultation or clinic visit outside the facility, the unit coordinator shall provide, for transportation with the residents, copies of the following documents:
   a. consultation request form completed by the requesting physician or NP;
   b. H&P form;
   c. latest monthly progress note with list of active medical problems;
   d. latest monthly medication order sheet and;
   e. the most recent laboratory test and radiology reports.

7. Pending consultations shall remain on the daily nursing report form until completion and shall be monitored daily by the unit manager or charge nurse.

8. The unit manager or charge nurse will periodically check with the consultant's office on the expected date of completion.

9. The nursing supervisor and attending physician shall be notified of uncompleted consultations after 7 days.

10. The medical director shall be notified of uncompleted consultations after 14 days.